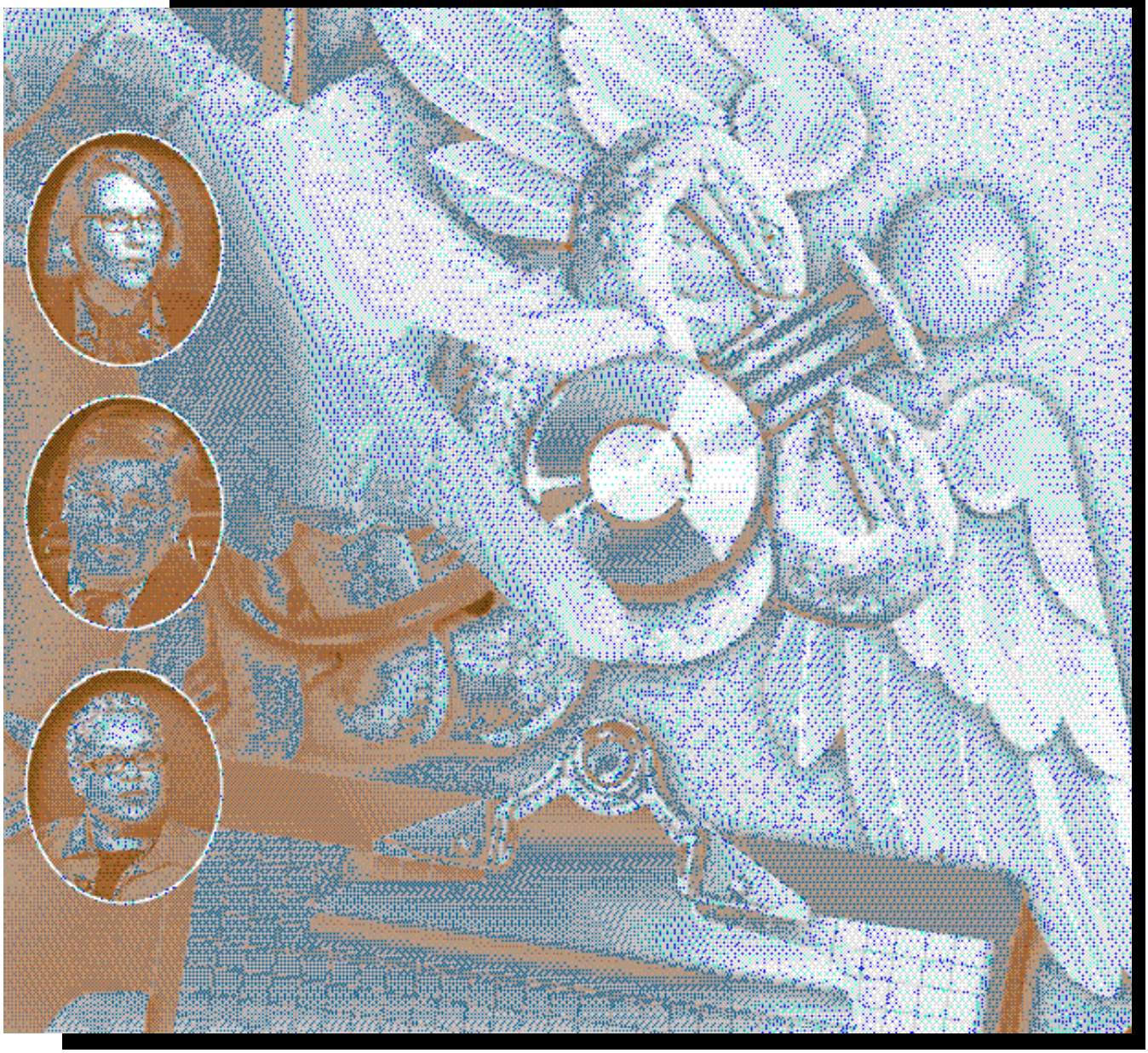
Iowan's
Talk About . . .

Examining Health Care

What's the Public's Prescription?



Welcome to the Forum

Welcome to "Iowan's Talk About … Examining Health Care: What's the Public's Prescription?" This issue book and forums grew out of the concerns people have about health care in Iowa and across the nation. The purpose is to:

- Better understand the issues and problems in health care;
- Examine different approaches for addressing these problems;
- Weigh the benefits and trade-offs of each approach;
- Identify common ground and issues that need further discussion; and
- Explore possible actions, individually and together.

This guide is based on the formal research of health care experts, as well as the personal accounts of some 1,200 Americans and Iowans regarding their health care experiences. It draws upon a National Issue Forum book entitled *Examining Health Care: What's the Public's Prescription?* and a book created by the West Virginia Center for Civic Life entitled *West Virginians Talk About … Examining Health Care: What's the Public's Prescription?* The information from these books is supplemented with data from Iowa and interviews with Iowans.

Credits

Anne Kinzel served as the lead author of this book with assistance from Sarai Beck, Jim Davis, Cal Halliburton, Gerry Ott, Jeanne Warning, and David Wilkinson. Sheri Michaels and Kathy Westcott handled the production responsibilities of the book.

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Examining Health Care

What's the Public's Prescription?

Introduction

America's health: Good, but good enough?

When Americans talk about health care, most say there's a lot to be thankful for. The United States boasts the most advanced medical technology in the world, helping millions of people live longer and healthier lives. World-class medical schools train health professionals in a wide range of specialties. Pharmaceutical research produces an ever-expanding array of prescription drugs that save lives and improve the quality of our lives.

At the same time, people have concerns about health care in America. They talk about waiting for hours to see their doctors, who then have only a few minutes to pinpoint and treat their problems. When specialists are needed, referrals are subject to close scrutiny and potential denial by insurers. And while there is an abundance of information available about health care, people do not use it. They may not know how to find the information or which sources to trust.

People often describe the care they receive as fragmented and incomplete. When a person has multiple providers for health care, there may be no one provider who takes responsibility for coordinating that care in a holistic way. In many cases, people lack access to certain services they view as essential to their health, such as preventive care, prescription drugs, and dental, vision, and mental health services.

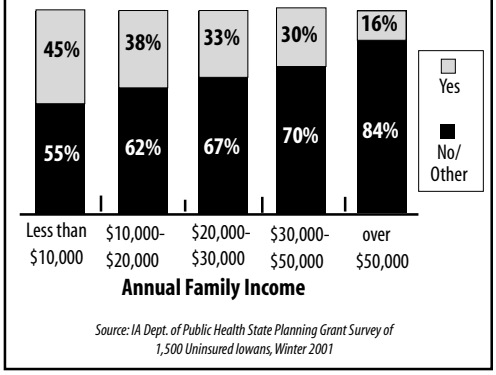
The problems are compounded for people without health insurance. For many, their only option is a hospital emergency room. They rarely see the same doctor twice. They may postpone care until their problems become critical and more difficult to treat. They delay care to avoid bills they cannot afford as is shown in Figure 1.

Health care consumers are not alone in their discontent. Health providers say that cost control pressures undermine good patient care. Employers say they can't meet the ever-escalating costs of health insurance plans. Insurers struggle to come up with plans that provide an ever-expanding array of services at an affordable cost. Government agencies that fund care for the poor and elderly say that tax dollars don't stretch far enough to meet the need.

Individuals and families, who have medical insurance, are finding their share of the costs sky rocketing.

Many believe that, unless bold steps are taken, the condition of health care is only going to get worse. The aging of the baby boomers, economic downturns, and threats to public safety place additional demands on a health care system that is already stretched to – and some say beyond – its limits.

Figure 1: Iowans who have large medical bills that are difficult to pay off



Source: IA Dept. of Public Health State Planning Grant Survey of 1,500 Uninsured Iowans, Winter 2001

Iowa's health: The same problems, only magnified

Improving health care is a daunting task because so many aspects of it seem to be in trouble. The problems that face the nation's health care are intensified here in Iowa, an aging state with many rural residents. A short list of compelling challenges shows how broad and complex the issue in Iowa really is:

Lack of insurance.

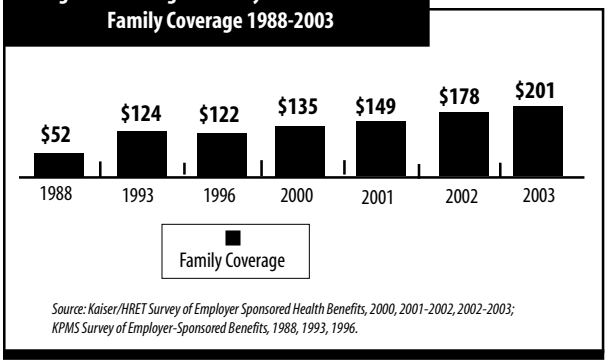
Iowa and the nation have made much progress in insuring our oldest and youngest citizens. Medicare, established by the Social Security Act of 1965, offers health coverage to nearly all our seniors. In Iowa, over 99 percent of persons over 65 are covered by health insurance, virtually all of the coverage coming from the Medicare program. [Source: Iowa HRSA State Planning Grant] In recent years, states have significantly expanded health coverage for children through Medicaid and the Children's Health Insurance Program (CHIP), which in Iowa is known as the **hawk-i** program. In Iowa, about 94% of children are now covered by some type of public or private health insurance plan, including 14,781 children enrolled in hawk-i as of April 2003.

A major problem is the number of working-age state residents who are uninsured. Most of these uninsured adults have jobs or live with someone who is employed. In 2002, the Census Bureau estimates there were about 274,000 working age (18-64) uninsured Iowans, or about 10.9 percent of persons between age 18 and 64. Research conducted by the Iowa Department of Public Health shows that in most cases, uninsured working-age Iowans are employed by businesses and organizations that do not offer insurance and these workers' wages are too low to purchase coverage privately.

Rising Costs.

Escalating health care costs are a concern to everyone, whether they have insurance or not. Managed care plans helped slow health insurance price increases during the 1990s, but costs have since returned to the double-digit inflation of the 1980s. Nationally, employer-sponsored health insurance premiums rose an average of 13.9 percent in 2002. In Iowa, the increase was 18.2 percent increase between 2002 and 2003. This followed an 18.7 percent premium increase between 2001 and 2002. Worker contributions towards their employer-sponsored health coverage have risen as well. The cost of family coverage has increased the most as shown in Figure 2.

Figure 2: Average monthly contribution for Family Coverage 1988-2003



Source: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2000, 2001-2002, 2002-2003; KPMS Survey of Employer-Sponsored Benefits, 1988, 1993, 1996.

In 2001, the average annual premium for employment-based, family health insurance coverage in Iowa was $7,106.35; the employer contribution was $5,377 (75.7%) and the employee contribution was $1,729.51 (24.3%). [Sources**:** Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2001 Medical Expenditure Panel Survey]

Rising costs also take a toll on public funders of health care. The average monthly rate of growth for Iowa's Medicaid program in 2001-2002 has been 8.6 percent. In 2000-2001, about 220,990 Iowans were enrolled in Medicaid, and about 100,000 Medicaid enrollees were children under 18. Most states, including Iowa, are grappling with sizable budget deficits and are hard

Iowa proportion of residents over 80 exceeds the proportion of the U.S. population that is over 80. Iowa ranks:

- **2nd in the nation in persons over 85 (2.2%)**
- **3rd in the nation in persons over 75 (7.7%)**
- **4th in the nation in persons over 65 (14.9%)**
- **4th in the nation in persons over 60 (19.0%)**

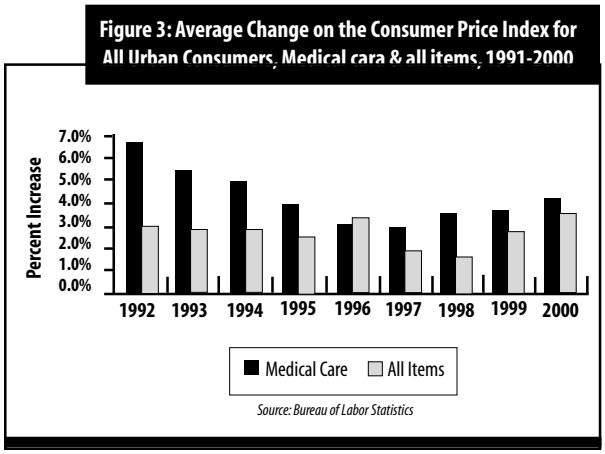
Source: Iowa Department of Elder Affairs

pressed to find the dollars needed to keep up with health care inflation.

Health care costs are higher and rising faster than consumer items in general.

Health provider shortages.

Even in the best of times, rural communities struggle to recruit and keep doctors and other health providers. The federal government has designated 59 of Iowa's 99 counties as "Medically Underserved Areas." In addition, many of Iowa's counties are considered federal "Health Professional Shortage Areas." Out of Iowa's 99 counties:



- 45 counties are designated as professional shortage areas for Primary Care Services, and
- 73 counties are designated as "Dental Health Care Shortage Areas." [Source: Iowa Dept. of Public Health Bureau of Health Care Access]

Its not just medical doctors who are in short supply. In 2000, the national supply of full-time equivalent (FTE) registered nurses was estimated at 1.89 million. The number of nurses needed was estimated to be 2 million, a shortage of 110,000 or 6 percent of the total nursing workforce. The shortage is expected to grow to 12 percent by 2010, 22 percent by 2015 and if nothing is done, the shortage will reach 29 percent by 2020.

Nursing shortages can greatly impact the quality of care hospital patients receive.

According to a study published in the October 23/30, 2002 issue of the *Journal of the American Medical Association*, more nurses at the bedside could save thousands of patient lives each year.

Another problem for many physicians, particularly those in specialties most subject to lawsuits, is the difficulty keeping their practices open due to the rising cost of malpractice insurance.

Burden of Chronic Disease

According to the US Centers for Disease Control and Prevention, several illnesses account for a majority of deaths.

- **Heart Disease**
  - In 1999, 8,699 deaths, or 31 percent of all deaths in Iowa, were due to heart disease.
- **Stroke**
  - In 1999, stroke was the cause of 2,317 Iowa deaths, or 8 percent of all deaths.
- **Cancer**
  - Cancer accounted for 22 percent of all deaths in Iowa in 1999.
  - The American Cancer Society (ACS) estimates that in 2002 there was 14,800 new cases of cancer diagnosed in Iowa, including 1,900 new cases of lung cancer, 2,000 new cases of colorectal cancer, and 2,400 new cases of breast cancer in women.
  - ACS estimates 6,400 Iowans died of cancer in 2002.
- **Diabetes**
  - In 2000, an estimated 121,000 adults in Iowa had diagnosed diabetes.
  - In 1999, diabetes accounted for 684 deaths in Iowa.

Troubling disparities.

Racial and ethnic minorities receive lower quality health care on average than whites do, according to studies conducted across the country. This is true even when income and insurance

status are comparable. Minorities are less likely to get the most appropriate heart medications or bypass surgery, cancer tests and treatments, or HIV drugs. They are more likely, on the other hand, to receive less desirable procedures, such as lower-limb amputations for diabetes.

Similar disparities appear to exist in Iowa. According to historical data from 1976 to 2000, the state's African-Americans are more likely to die from cancer than Caucasians. In fact, in 1999, cancer deaths from all cancers were 58 percent higher among African-Americans than Caucasians. Currently, the rate of death from stroke was 31 percent higher among African-Americans than Caucasians. Cancer death rates from all cancers were 58 percent higher among African-Americans than among Caucasians.

Iowans health insurance coverage also varies by race and ethnicity; 9 percent of whites are uninsured, versus 13 percent of African-Americans, and 23 percent of Hispanics. [Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, 2001-2002]

One of the challenges of correcting this differential treatment is that it's not always conscious or intentional. An Institute of Medicine report concluded that "although it is reasonable to assume that the vast majority of health care providers find prejudice morally abhorrent, several studies show that well-meaning people who are not overtly biased or prejudiced typically demonstrate unconscious racial attitudes and stereotypes."

Unhealthy choices.

While some causes of illness and disease are beyond our control, others are not. A great deal is known about the effects of diet, exercise, alcohol, and tobacco on health status, yet many Americans make choices that are detrimental to their health.

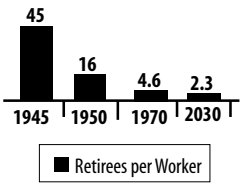
Iowans suffer from health problems related to lifestyle. Too many Iowans are obese, with 22.9 percent obese in 2002 versus 12.8 percent in 1990. An additional 38 percent of the population is medically overweight. [Source: BRFSS] A significant number of Iowans, 21.8 percent, report that they do not engage in any physical activity during their leisure time.

Aging baby boomers.

As the baby boomers get older and need more health care, they are likely to place further strain on health resources. This will be acutely felt in Iowa where the median age has increased to 36.6 years, (30.0 in 1980) (US Census).

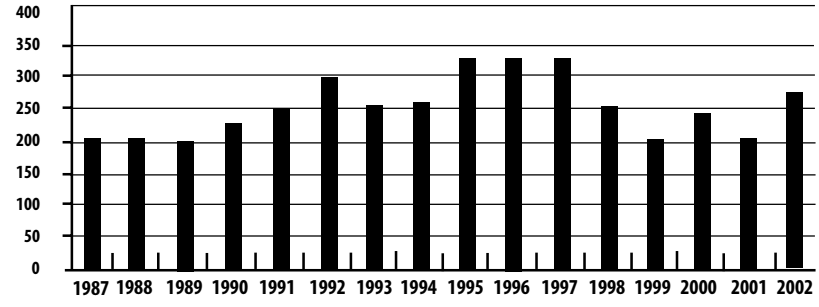
Nationally, Medicare's financial survival is seriously challenged by the country's aging population. Not only will there be more beneficiaries as baby boomers retire, but there will also be fewer workers paying into the system. Economists say that without reform, demographic and cost trends will drive Medicare to unaffordable levels.

Medicare in Jeopardy: Fewer Workers per Retiree



Source: Center for Disease Control and Prevention

Uninsured Iowans Under 65
1987 to 2002
In 1000s



Source: U.S. Census Bureau

Approach 1

Care for All, Not Just for Some

hawk- i Who's eligible?

Hawk-i covers children ages 18 and under in families with incomes up to 200 percent of the federal poverty level. For example, a family of four earning up to $36,800 a year or $3,016 a month may now be eligible for coverage. Since Iowa also allows a 20 percent earned-income adjustment for families applying for hawk-i, some children in families with incomes above 200 percent may qualify for hawk-i.

Many Iowans went without health care they needed sometime during the past year because of cost. And it's not just poor and uninsured people who are falling between the cracks. In 2000, approximately 19.4 percent of Iowa's uninsured families had family incomes of over $50,000. Even families who have health insurance still face big bills for eyeglasses and dental care not covered by their policies. Many seniors go without needed prescription drugs that Medicare doesn't cover.

Supporters of Approach One say we need a system where all people have some kind of health coverage that enables them to get timely, appropriate, and affordable care. Some say we should accomplish this goal by providing additional tax incentives to employers who offer insurance and by expanding government-sponsored health programs like Medicaid.

In Iowa, about 147,400 out of uninsured persons are considered "low income," that is with family incomes of approximately $30,000 per year for a family of 4. Yet eligibility for Medicaid, the public insurance program, remains restricted for non-elderly adults, even though the federal government funds three-quarters of the program's cost.

Other supporters of this approach say that we need more than state-by-state strategies. They say the best way to assure universal coverage is to revamp the way health care is financed in this country and make the federal government the primary insurer of all Americans.

Approach One calls for health plans that cover the "whole person." Health plans need to include all services that are essential to good health and stop treating mental health, prescription drugs, dental care, and vision services as optional extras.

But having health insurance is of little value if people don't have physical access to services. In Iowa, we need to address the formidable barriers of health provider shortages and lack of public transportation. We also need to do everything we can to correct differential treatment based on race and gender so that everyone has equal access to quality health care.

Iowa Medicaid/hwk-i Eligibility Levels for Various Enrollment Groups Family Income Based on a Family Size of 3

	U.S. Poverty Level	Family Income
Medicaid		
Pregnant Women	200%	$30,520
Infants — Age 0-1 year	200%	$30,520
Children — Ages 1-5	133%	$19,258
Children — Ages 6-19	133%	$19,258
Medically Needy Individual	67%	$ 6,016 (Individual Income)
Children —hawk-i	200%	$30,520

What can be done?

- State government could raise the income eligibility limits for Medicaid to cover more working-age adults.

- Iowa could allow adults to purchase coverage under hawk-i. Right now the hawk-i program only provides coverage to children and not to their parents.

- Community volunteers could provide patient transportation, and health providers could donate some of their services to those in need.

- Health providers could use more satellite offices and mobile units to reach underserved areas of the state.

- Medical schools could conduct more research and training aimed at reducing racial and gender disparities in health care.

- Congress could add prescription drug coverage to Medicare, or go even further by establishing a nationwide system of universal coverage.

I don't know how much I will be making from month to month, but the payments for health insurance have to be paid on time, regularly.
— Central Iowan

"If you make between $18,000 and $21,000 per year you are stuck between a rock and a hard place."
— Eastern Iowan

Concerns about Approach One

- If we spend more of the public pie on health care, what other public services are we willing to reduce or live without?

- If we provide comprehensive care to everyone, will we overwhelm the health care system, causing shortages, rationing, and long waits?

- Will too much government involvement turn health care into another welfare program, giving people less incentive to work and employers less reason to offer health insurance?

- Will providing universal coverage create unrealistic expectations of the health care system that we simply cannot afford?

Approach 2

Partners, Not Just Patients

How people are treated – personally, as well as medically – has a significant effect on their ability to heal and stay well. People want relationships with health professionals they know and trust. They want providers who listen to their concerns and discuss their options. And they want insurers who honor their choices.

In this approach, the doctor-patient relationship has always been and always will be at the heart of health care. No matter how much we spend on health care or how it's managed and coordinated, it cannot improve significantly until patients, their doctors and insurers refashion their relationship and put patients at the center of health care decisions.

The National Institute of Mental Health defines patient-centered care as "health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences, and solicit patients' input on the education and support they need to make decisions and participate in their own care." The institute conducted research that found that patients who are active participants in their own care experience better results than those who are not.

A state like Iowa, with a significant rural population, also faces shortages of medical services within communities. It is difficult for a patient to be a partner when no medical professional is nearby.

Supporters of Approach Two say that health care is a two-way street of rights and responsibilities. "Why should we pay for other people's bad habits?" they ask, referring to studies showing that too many Iowans are making unhealthy lifestyle choices. They point to cigarettes and chewing tobacco as prime examples. Health care costs in the state directly caused by tobacco use top $500 million each year and claim 3,800 lives, a tragic toll that is so clearly preventable.

What can be done?

- Individuals could take more responsibility for choosing healthy lifestyles and getting regular check-ups.

- Insurers and health care administrators could support more face-to-face time between patients and their health providers.

- Medical schools could focus more on doctor-patient collaboration and patient-centered care.

- Employers could involve employees in decisions about health plans, benefits, and costs.

- The state legislature could raise tobacco taxes to deter smoking, thereby saving money and lives.

- Congress could pass a law to protect patients' rights to appeal decisions by insurers.

When I go to visit my physician, I bring the prescriptions I'm taking. I bring a chart that goes back five or six years with my cholesterol levels, when I had my colonoscopy, and so on. It's all right there. I cooperate with my primary care physician, and I want him to know I appreciate him. I missed an appointment not long ago, and I never miss appointments. Would you believe he called me that afternoon to ask if I was okay? I feel very blessed to have the physician I have.

— Patient

Concerns about Approach Two

- Will the time-consuming work of changing relationships distract us from working on other serious problems, like expanding health coverage to the uninsured?

- Aren't most people concerned more about their doctors' clinical competence than their bedside manner?

- What would happen to people who are not willing or able to be active partners in their health care?

- Will additional demands on doctors' and nurses' time strain a system that is already stretched too thin?

Approach 3

Connected Parts, Not Fragmented Pieces

We call our current method of delivering health care “a system,” but it’s often chaotic and disjointed, with each of its many hands not knowing what the others are doing. At a personal level, patients often feel they are being farmed out to different specialists with no one paying attention to the big picture.

The result is a situation ripe for medical mistakes, waste, and fraud. Every year, at least 44,000, and maybe as many as 98,000 persons, die in U.S. hospitals as a result of medical errors that many experts believe were preventable. The cost to the medical care system of preventable errors is estimated at between $17 and $29 billion in additional hospital costs nationwide. Health care fraud drains an additional $54 million annually.

The health care business is built largely on assumptions that competition between hospitals, between insurers, and between drug companies keeps costs down and quality high. Approach Three says that these assumptions don’t hold up when it comes to health care. What is needed is more collaboration and coordination among health providers. We need to connect all the fragmented, inefficient pieces of health care into an effective system, where information flows readily and the various parts work in concert.

We also need to curtail unnecessary and often costly tests and procedures, which some doctors prescribe because they’re concerned about potential lawsuits in the future. Many physicians, particularly those in higher risk specialties like obstetrics, say the rising cost of medical malpractice insurance is driving doctors out of business or out of state. Supporters of Approach Three want to see legislative action aimed at setting a cap on malpractice awards for actual damages on pain and suffering awards.

What can be done?

- Individuals could play a more active role in understanding and coordinating their own care.

- Health care providers could develop systems to make it easier to share patient information.

- Insurers could set stricter guidelines to reduce unnecessary medical tests, and medical schools could educate physicians to use costly procedures efficiently.

- The legislature could discourage the costly practice of defensive medicine by setting additional caps on medical malpractice awards.

- Congress could establish a nationwide, mandatory reporting system to monitor and learn from medical mistakes.

- State and federal agencies could increase their monitoring of health care billing practices and stiffen penalties for fraud.

Very few medical events are actually emergencies. A lot of problems can actually be prevented, but unfortunately in our country, we don't do a lot of preventative medicine, even if you are insured, because its just not available at any price.

— Iowa Health Care Executive

The only way you can get insurance is through a job. Its too expensive to pay on your own.

— Uninsured Iowan

Concerns about Approach Three

- Is it wise to use our scarce health care dollars on more administrative systems rather than on direct care to patients?

- Will this approach add extra layers to a health care system already choked with bureaucracy?

- How can we make it easier for health providers to share patient information without jeopardizing personal privacy?

- Is it the faltering stock market, where insurance companies have their money invested, – not lawsuits – that's driving up the cost of malpractice insurance?

Malpractice coverage has become an expensive cost of doing business because disgruntled patients now regularly file multimillion dollars lawsuits. Nationally, jury awards increased 43 percent in one year, from a median of $700,000 in 1999 to $1 million in 2000, according to Jury Verdict Research, a for-profit company that maintains a database of nearly 200,000 verdicts and settlements resulting from personal injury claims.

Which way forward for Iowa?

In this forum, we have explored three different approaches for improving health care for Iowa. Though the approaches overlap in some respects, they propose different priorities for action that would bring different benefits and trade-offs.

Forums such as these are based on the belief that we must talk and act together in order to tackle the challenges that face our communities, state and nation. In closing this forum, we will consider the following questions to help us think about what we should do to improve health care in Iowa.

- What did we learn?
- What new information or insights did you gain as you listened to other participants in the forum, whether or not you agreed with their perspectives?
- Where do we agree?
- What actions do most of us support to improve health care in Iowa?
- What actions do most of us oppose?
- What trade-offs are most of us willing and not willing to make to improve health care?
- Where do we disagree?
- What are the areas of disagreement in the group, and why?
- What can we do?
- What can we do individually and together as a result of this forum?